DMAS-353

EPSDT Medical History Form

This form may be used in conjunction with the EPSDT Periodicity Schedule to document all components of screenings examination.

NAME_____ DOB_____ Check here if child is in foster care:_____

MOTHER'S NAME:	PHONE:	Allergies:
FATHER'S NAME:	PHONE:	
Family Medical History:		Hospitalizations/Surgery
Allergic Disorders:		
Blood Disorders:		
Cancer:		
Diabetes:		
Heart Disease/Hypertension:	Illnesses:	Date:
Seizure Disorder:		
Tuberculosis:		
Other(s):	Medications:	
Siblings:		
Person Medical History: BIRTH DATA: WT: Length: Type of delivery Apgar 1min_____Feeding 5min_____	HC:	